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## Editorial – A personal view

# Funding and efficiency in the National Health Service

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It may be that by the time this is read some truce will have occurred to halt the vicious war between the British Medical Profession (almost united at present) and the British Government over the Government's White Paper heralding the re-organisation of the National Health Service along business lines. The underlying conflicts are unlikely however to have been resolved. They are worth scrutinising.

First an outline of the White Paper's proposals (1). Control of the NHS is to be de-centralised; an internal market is to be set up so that if patients from one health authority's area are treated in another, money will 'follow the patient' and be paid by one authority to the other; hospitals who want to run their own shows can become self-governing hospital trusts, while staying within the NHS – they will be able to set their own rates of pay, and earn revenue from the medical services they provide; large general practices can also run their own shows, and be given cash-limited practice budgets with which to buy hospital services from the public or private sector; all GPs will be given 'indicative budgets' for their drug prescribing and will have to justify any spending above these 'indicative' ceilings. The NHS will be in direct commercial competition with the private medical sector and the NHS will be able to buy services from the private sector; management of the NHS will be 'reformed on business lines'; and the system of medical peer review known as 'audit' will be extended. The Government's expressed rationale for all this is straightforward, and essentially rests on the objective of improving services for patients by increasing the *efficiency* with which the mammoth National Health Service is run, and thus getting a better service for the 26 billion pounds per annum currently spent by Government on the NHS on behalf of, and using taxes raised from, the population: thus the Government's objective in the White Paper, as its title 'Working for Patients' (1) indicates, is improved health care under the NHS.

The medical profession's view (it is rare to be able to talk accurately in such broad generalisations but this is an occasion where the profession is – at the time of writing at least – so united in its rejection that this generalisation seems justified) is that the White Paper reforms will actually cause deterioration in patient care, while totally failing to address the real problem of

the NHS which is chronic Government underfunding. Political opponents of the White Paper, including Her Majesty's Opposition, espouse two main Government objectives underlying the White Paper's proposals – first, straightforward cost-containment of Government spending on the NHS; second, what they see as a more sinister and unavowed objective, notably the gradual and covert destruction of the National Health Service and its replacement by a two-tier system of health care on American lines, with the bulk of health care being provided through private health insurance, leaving a residual and minimal national 'safety net' system of health care provision for those too poor – or ineffectual – to provide their own insurance.

At the invitation of the British Broadcasting Corporation I was able, earlier this year, to interview a variety of leading combatants in the conflict in order to discuss the ethical perspectives that underlay their stances on the White Paper. As a result of those discussions – only short extracts of which could actually be used in the resulting 45-minute radio programme (2) – various conclusions became clearer, at least in my own mind, and they may be of some more general interest.

The first is that the demand for resources for the provision of health care is enormous and ever-increasing, and satisfying it is ever more expensive. Increased efficiency, while it may temporarily free additional resources to meet some of the additional demand, cannot meet this increased demand for long. The demand stems from two things: first a health-care need (most ill people have health-care needs – either to get better – improve the quality of their lives – and/or to stave off undesired death and go on living – improve the length or 'quantity' of their lives): second, the possibility of satisfying that need. Thus, as ever more health-care techniques are developed to satisfy people's health-care needs, so ever more health-care demand is created. Occasionally new methods of health-care supersede and replace existing methods, even more occasionally they do so cost-effectively – that is to say they obtain the same desired health-care objective more cheaply than before. In the large majority of cases, however, advances in the techniques of health-care do not replace, but add to, existing techniques and thus cost additional money if

introduced. So the development of most new health-care techniques will both increase health-care demand and increase health-care expense if that demand is met. Hardly a new or revolutionary conclusion but one that many – on both sides of the conflict – are reluctant to confront explicitly.

My second conclusion is that in Britain there is widespread acceptance, even at the highest levels of Government, of a national obligation to provide a national health service to meet the medical needs of those who are sick. There is even a widespread acceptance of a national obligation to provide a national health *promotion* service, aimed not merely at dealing with existing illness and disease but at enhancing people's existing levels of health and at preventing (or at least postponing) disease, disability and death. One might have expected a Government so heavily committed to *laissez-faire* liberalism as is Mrs Thatcher's to have disavowed such State involvement in the provision of health care, on the grounds that the State has a duty to 'get off the backs' of the people, reduce taxation, encourage self-reliance in health care, and abolish a nanny National Health Service. But when I put this to the Secretary of State for Health, The Rt Hon Kenneth Clarke, he was scathing about my analysis of Government philosophy. Conservatives, he told me, while they were certainly in favour of privatising manufacturing and trading industries, had 'years ago accepted the duty of Government to provide a good high standard of public service'. He was adamant – and I have to say I believed he was sincere – that there was no intention at all of abolishing the National Health Service. Certainly that is explicitly affirmed in Mrs Thatcher's personal introduction to the White Paper. Perhaps the strongest reason to believe it is that it would almost certainly be political suicide to abolish the NHS – the British people, it is probably safe to assert, are extremely fond and proud of the institution.

Mr Clarke was equally explicit that the White Paper was not a means of cost-containment or rationing in response to the ever-increasing demands for more and better health-care described above. Although he declined to give a commitment that the percentage of Gross National Product (GNP) spent by Government on health care would be maintained, he asserted that he fully expected it to rise: 'The rising demands of the population for health care I think make it almost certain that we are going to have to devote a growing proportion of our wealth to it'. However, such optimism would not seem to be justified by his Government's record: apparently Mrs Thatcher's Governments have increased the rate of growth of real expenditure on the NHS less than any other Government since 1959 (3).

However, cost-containment was not the purpose of the White Paper, Mr Clarke repeatedly affirmed; its purpose was simply to make the health service work better for patients and thus provide better value for money. 'If you run a health service badly, so that you

waste the money, you produce a lower standard of care than you would do if you run it efficiently'. The Government's proposals, including indicative drug budgets, medical audit, internal markets and de-centralisation of control within national norms, are means, in the Government's firm view, of obtaining such improved efficiency and thus better value for money.

It is quite clear to me that the leaders of the medical profession are entirely happy to *co-operate* with Government in achieving improved efficiency and better patient care (though they feel that compared with most other health-care systems the NHS is already very *efficient* in squeezing out of a mere six per cent of a fairly modest GNP the extensive and reasonably equitably distributed medical care that it already provides – a feeling that in America I know to be widely shared). They are interested in developing the already widespread informal methods of self-scrutiny or 'medical audit' and are ready to use such methods to scrutinise their practice when it results in costs that are markedly higher than those of their peers. If those costs cannot be justified by patient needs and good clinical practice they are prepared to take the advice of their peers and change their practice. They are even prepared to co-operate with the new business-orientated approach outlined in the White Paper – if these methods can be shown by means of proper pilot studies actually to improve patient care and without unacceptable 'side-effects' (such as undermining, for example by too much emphasis on cost-saving, the special relationship between doctors and their patients that is at the heart of good medical care). Pilot studies of the efficacy of the White Paper's proposals should surely be welcomed by the Government for these would conform to the fundamental objective of the White Paper itself of ensuring that all practices in the NHS were rigorously scrutinised to ensure that they provided good value for money in meeting the medical needs of patients.

But in return for its co-operation the medical profession wants the chronic underfunding of the NHS remedied. There is widespread demoralisation within the service, which is attributed by those who work in it to serious underfunding leading to an ever-decreasing possibility of providing patients with a modern and excellent health service throughout the country. If, as Dr John Dawson of the BMA told me, there really is a problem of inadequate national resources so that excellent care for everybody can't be provided – if for example the ever-increasing numbers of elderly in the population pose problems of what the exchequer can or can't afford in terms of total medical care for old people then 'we should have an honest and open debate about what we can afford to do...'

That debate needs to encompass several components: what health-care needs ought to be met by a national health service and which (if any) need not

to God and in God's eyes. But the report explicitly disclaims any reliance on theological premises [148] and without that support the questions must be faced, and they are not always easy to answer.

Most people cling to their own lives even when those lives seem to others, and even to themselves, starkly miserable. But some do not; there comes a time when they find life insupportable and they long for release. If the autonomy of the patient is to be paid more than lip-service we must allow people to answer questions about the value of their lives for themselves. Certainly there are cases in which a person's life is of value to others, for example if he is the sole breadwinner of a family which will be left destitute at his death. But this type of case must be very rare in the circumstances envisaged by the legislation proposed by the VES. Certainly too, survivors grieve when someone dies; but that grief is coming to them in any case, and the tragedy lies, not in the AVE but in the conditions that led to its request.

The report even goes so far as to suggest that life should be prolonged against a person's will because doctors themselves may get something out of it. That, at least, seems to be the meaning of the following sentence taken from Section 62 on the disabled who are

not terminally ill. 'It is a far more demanding and challenging task to attempt to discover value in the terrible situation that exists, but it is more in accord with the ethos of medicine to make that attempt than to kill the patient'. That the working party can refer to *voluntary* euthanasia as 'killing the patient' is a measure of the open-mindedness and sensitivity with which it approached its task.

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## References

- (1) British Medical Association. *Euthanasia*. London: BMA, 1988.
- (2) British Medical Association. *The handbook of medical ethics*. London: BMA, 1984:65.
- (3) NOP/9114, March 1987.
- (4) France: VES newsletter 1988; 32; Canada: *Dying with dignity: newsletter* 1985; 7; USA: *Hemlock quarterly* 1989; 29.
- (5) *Sunday Telegraph* 1986 Nov 30.

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be (with correlative debate about what counts as a health-care need and what as a mere health-care *want*; and how can satisfaction of such needs best be *measured*); how much tax for health care can Government justifiably levy?; what are the proper principles whereby Government should undertake the macroallocation of the overall 'tax cake' between competing State objectives such as education and defence – and given some overall Government allocation to health care, how should it be distributed equitably in the face of competing health-care needs, if it is agreed that not all those needs can be met. In the face of the inexorable – and indeed often literally

wonder-ful – development of new and effective health-care techniques, such a debate and a proper mechanism for encouraging and sustaining it – becomes ever more necessary.

## References

- (1) *Working for patients*. London: HMSO, 1989.
- (2) Analysis. *The doctors' dilemma*. BBC Radio 4, June 1 and 2, 1989.
- (3) Wells J. Official statistics indicate an unprecedented squeeze on NHS resources since 1981 [letter]. *Financial Times* 1989 Feb 11.

## News and notes

### Ethical issues in *in vitro* fertilisation

A new 'scope note', Scope note 10, on Ethical issues in *in vitro* fertilisation, has been published by the Kennedy Institute in America. It lists important committee statements and offers an annotated bibliography on the legal, philosophical, public policy and religious aspects of the procedure.

Scope notes, the Kennedy Institute points out, are not designed to be comprehensive reviews, but to

bring together recent information related to specific topics in biomedical ethics.

Copies are available from: the National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University, Washington, DC 20057, USA. Cost is \$3.00 prepaid and \$5.00 outside the USA and Canada.